h. Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

(1) Care in a nursing facility or an intermediate care facility for the mentally retarded.

(2) Care in an institution for mental disease.

(3) Care in a Medicare-certified skilled nursing facility.

(4) Rehabilitative treatment services pursuant to 441—Chapter 185.

i. Reviews. Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy recipients with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118, Medically Needy Recertification/State Supplementary and Medicaid Review, as part of the review process when requested to do so by the county office.

j. Redetermination. When an SSI-related, CMAP-related, or FMAP-related recipient who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the recipient's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Medically Needy Recertification/State Supplementary and Medicaid Review, Form 470-3118, shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on recertifications. A face-to-face interview is not required for recertifications if the last face-to-face interview was less than 12 months ago and there has not been a break in assistance. When the length of time between face-to-face interviews would exceed 12 months, a face-to-face interview shall be required.

k. Recertifications. A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medically Needy Recertification/State Supplementary and Medicaid Review, Form 470-3118, to be recertified. This form shall be treated as an application. For cases on the X-PERT system, if an interview is required as specified at subparagraph 75.1(35)*"j"*(2), the applicant may complete Form 470-3112 or 470-3122 (Spanish). When the applicant completes Form 470-3112 or Form 470-3122 (Spanish), the Summary of Facts, Form 470-3114, shall be completed and attached to the Summary Signature Page, Form 470-3113 or Form 470-3123 (Spanish), which has been signed and returned to the local or area office.

If an interview is not required as specified at subparagraph 75.1(35)*"j"*(2), when the Application for Assistance, Part 1, Form 470-3112 or 470-3122 (Spanish), is completed, the applicant shall be requested to complete Form 470-3118.

l. Disability determinations. An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, a Disability Report, Form 470-2465, must be obtained from the applicant or recipient or the applicant's or recipient's authorized representative. A signed Authorization for Source to Release Information to the Department of Human Services, Form 470-2467, shall be completed for each medical source listed on the disability report.

(3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility.

75.1(36) *Expanded specified low-income Medicare beneficiaries.* Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

a. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

c. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

d. The person is not otherwise eligible for Medicaid.

e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(37) *Home health specified low-income Medicare beneficiaries.*

a. Medicaid benefits to cover the cost of the home health portion of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

(1) The person's monthly income is at least 135 percent of the federal poverty level but is less than 175 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(2) The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

(3) The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

(4) The person is not otherwise eligible for Medicaid.

b. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

c. Payment of the home health portion of Medicare Part B premium shall be made retroactively on an annual basis in April of each year for the prior calendar year.

75.1(38) *Continued Medicaid for disabled children from August 22, 1996.* Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

75.1(39) *Working persons with disabilities.*

a. Medical assistance shall be available to all persons who meet all of the following conditions:

(1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.

(2) They are less than 65 years of age.

(3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards.

(4) They receive earned income from employment or self-employment or are eligible under paragraph *"c."*

(5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to $10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph (1) above.

(6) They have paid any premium assessed under paragraph *"b"* below.

b. A monthly premium shall be assessed when gross income of the eligible individual is greater than 150 percent of the federal poverty level for an individual. Gross income includes all earned and unearned income of the eligible individual.

Beginning with the month of application, the monthly premium amount shall be established for a six-month period based on projected average monthly income for the six-month period. The monthly premium established for a six-month period shall not be increased during the six-month period but may be reduced or eliminated prospectively during the period if a reduction in projected average monthly income is documented.

Eligible persons with income above 150 percent of the federal poverty level are required to complete and return Form 470-3693, Earned Income Statement for Premium, with income information to determine premium amount.

(1) Premiums shall be assessed as follows:

INCOME OF THE ELIGIBLE INDIVIDUAL ABOVE:	MONTHLY PREMIUM
150% of Federal Poverty Level	$20
174% of Federal Poverty Level	$38
198% of Federal Poverty Level	$56
222% of Federal Poverty Level	$74
246% of Federal Poverty Level	$92
270% of Federal Poverty Level	$110
294% of Federal Poverty Level	$128
318% of Federal Poverty Level	$146
342% of Federal Poverty Level	$164
366% of Federal Poverty Level	$182
390% of Federal Poverty Level	$201

(2) Eligibility for a month is contingent upon the payment of any assessed premium for the month. Except as provided in subparagraph (3), continued eligibility is contingent upon the payment of all assessed premiums.

(3) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. Payment of the premium for the two months following the month of approval must be received by the fourteenth day of the month following the month of approval.

2. Payments for retroactive months, months prior to the month of approval, and approval month must be paid within 60 days of notice by the department to receive coverage for those months of eligibility.

3. After the month following the month of approval, premiums must be received no later than the fourteenth day of the month prior to the month of coverage.

When the premium is not received by the due date, Medicaid eligibility shall be canceled, except when the premium not received is due during or after the month of coverage.

At the request of the client, premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

(4) An individual's case may be reopened no more than once every six months when a premium due is not received as described within this subparagraph. However, the premium must be paid in full within the calendar month following the month of nonpayment for reopening.

(5) Premiums may be submitted in the form of cash, money orders, or personal checks to the department at the following address: Department of Human Services, Supply Unit A-Level, Room 77, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319.

(6) Except as provided in subparagraph (3), failure to pay the premium in accordance with policy established under this paragraph shall result in cancellation of Medicaid. Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(7) A medical card shall not be issued for a month until any premium due has been received. When a premium is not received by the due date, a notice of decision will be issued to cancel Medicaid, except as provided in subparagraph (3). The notice will include reopening provisions that apply if payment is received and appeal rights.

(8) Form 470-3694, Billing Statement, and Form 470-3695, Reminder of Nonpayment, shall be used for billing and collection.

c. Persons receiving assistance under this coverage group who become unable to work due to a change in their medical condition or who lose employment shall remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule.

d. For purposes of this rule, the following definitions apply:

"Assistive technology" is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices and assistive technology services.

"Assistive technology accounts" include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices or assistive technology services. Assistive technology accounts must be held separate from other accounts and funds and must be used to purchase, lease or otherwise acquire assistive technology, assistive technology services or assistive technology devices for the working person with a disability when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual's employment.

"Assistive technology device" is any item, piece of equipment, product system or component part, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities or address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

"Family," if the individual is under 18 and unmarried, includes parents living with the individual, siblings under 18 and unmarried living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, "family" includes the individual's spouse living with the individual and any children living with the individual who are under 18 and unmarried. No other persons shall be considered members of an individual's family. An individual living alone or with others not listed above shall be considered to be a family of one.

"Medical savings account" means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

"Retirement account" means any retirement or pension fund or account, listed in Iowa Code section 627.6(8)*"f"* as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

75.1(40) *Women who have been screened and found to need treatment for breast or cervical cancer.*

a. Medical assistance shall be available to women who:

(1) Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and have been found to need treatment for either breast or cervical cancer (including a precancerous condition);

(2) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg(c)(1)), and are not eligible for medical assistance under Iowa Code section 249A.3(1); and

(3) Are under the age of 65.

b. Eligibility established under paragraph *"a"* continues until the woman is:

(1) No longer receiving treatment for breast or cervical cancer;

(2) No longer under the age of 65; or

(3) Covered by creditable coverage or eligible for medical assistance under Iowa Code section 249A.3(1).

c. Presumptive eligibility. A woman who has been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, who has been found to need treatment for either breast or cervical cancer (including a precancerous condition), and who is determined by a qualified provider to be presumptively eligible for medical assistance under paragraph *"a"* shall be eligible for medical assistance until the last day of the month following the month of the presumptive eligibility determination if no Medicaid application is filed in accordance with rule 441—76.1(249A) by that day or until the date of a decision on a Medicaid application filed in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, whichever is earlier.

The woman shall complete Form 470-2927, Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. Presumptive eligibility shall begin no earlier than the date the qualified Medicaid provider determines eligibility.

Payment of claims for services provided to a woman under this paragraph is not dependent upon a finding of Medicaid eligibility for the woman.

(1) A provider who is qualified to determine presumptive eligibility is defined as a provider who:

1. Is eligible for payment under the Medicaid program; and
2. Either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or
- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

3. Has made application and has been specifically designated by the department in writing as a qualified provider for the purpose of determining presumptive eligibility under this rule.

(2) The provider shall complete Form 470-3684, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), and submit it to the department for approval in order to be designated as a provider qualified to make presumptive eligibility determinations. Once the department has approved the provider's application, the provider and the department shall sign Form 470-3865, Memorandum of Understanding with a Qualified Provider for Women with Breast or Cervical Cancer Treatment. When both parties have signed the memorandum, the department shall designate the provider as a qualified provider and notify the provider.

(3) When a qualified provider has made a presumptive eligibility determination for a woman, the provider shall:

1. Contact the department to obtain a state identification number for the woman who has been determined presumptively eligible.
2. Notify the department in writing of the determination within five working days after the date the presumptive eligibility determination is made. The provider shall use a copy of Form 470-2580, Presumptive Medicaid Eligibility Notice of Decision, for this purpose.
3. Inform the woman in writing, at the time the determination is made, that if she has not applied for Medicaid on Form 470-2927, Health Services Application, she has until the last day of the month following the month of the preliminary determination to file the application with the department. The qualified provider shall use Form 470-2580, Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

4. Forward copies of Form 470-2927, Health Services Application, to the appropriate department office for eligibility determination if the woman indicated on the application that she was applying for any of the other programs. The provider shall forward these copies and proof of screening for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program within two working days from the date of the presumptive eligibility determination.

(4) In the event that a woman needing care does not appear to be presumptively eligible, the qualified provider shall inform the woman that she may file an application at the county department office if she wishes to have an eligibility determination made by the department.

(5) Presumptive eligibility shall end under either of the following conditions:

1. The woman fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

2. The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and is found ineligible for Medicaid.

(6) Adequate and timely notice requirements and appeal rights shall apply to an eligibility determination made on a Medicaid application filed pursuant to rule 441—76.1(249A). However, notice requirements and appeal rights of the Medicaid program shall not apply to a woman who is:

1. Denied presumptive eligibility by a qualified provider.

2. Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the woman fails to file an application by the last day of the month following the month of the presumptive eligibility determination.

(7) A new period of presumptive eligibility shall begin each time a woman is screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, is found to need treatment for breast or cervical cancer, and files Form 470-2927, Health Services Application, with a qualified provider.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6.

441—75.2(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through Veterans' Administration, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources for meeting the cost of medical care which may be available to the recipient. These resources must be used when reasonably available.

When a medical resource may be obtained by filing a claim or an application, and cooperating in the processing of that claim or application, that resource shall be considered to be reasonably available, unless good cause for failure to obtain that resource is determined to exist.

Payment will be approved only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable. Persons who have been approved by the Social Security Administration for supplemental security income shall complete Form MA-2124-0, Supplementary Information—Medicaid Application—Retroactive Medicaid Eligibility, and return it to the local office of the department of human services. Persons eligible for Part B of the Medicare program shall make assignment to the department on Form MA-2124-0, Supplementary Information—Medicaid Application—Retroactive Medicaid Eligibility.

75.2(1) The recipient, or one acting on the recipient's behalf, shall file a claim, or submit an application, for any reasonably available medical resource, and shall also cooperate in the processing of the claim or application. Failure to do so, without good cause, shall result in the termination of medical assistance benefits. The medical assistance benefits of a minor or a legally incompetent adult recipient shall not be terminated for failure to cooperate in reporting medical resources.

75.2(2) When a parent or payee, acting on behalf of a minor, or of a legally incompetent adult recipient, fails to file a claim or application for reasonably available medical resources, or fails to cooperate in the processing of a claim or application, without good cause, the medical assistance benefits of the parent or payee shall be terminated.

75.2(3) Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the recipient, or one acting on behalf of a minor, or of a legally incompetent adult recipient, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

a. Physical or emotional harm to the recipient for whom medical resources are being sought.

b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult recipient, for whom medical resources are being sought.

75.2(4) The determination of good cause shall be made by the Utilization Review Section of the Bureau of Medical Services. This determination shall be based on information and evidence provided by the recipient, or by one acting on the recipient's behalf.

75.2(5) When the department receives information through a cross-match with department of employment services and child support recovery files which indicates the absent parent of a Medicaid-eligible child is employed, the department shall send Form 470-0413, Absent Parent Insurance Questionnaire, to the absent parent in order to obtain health insurance coverage information. If the absent parent does not respond within 15 days from the date Form 470-0413 is sent, the department shall send Form 470-2240, Employer Insurance Questionnaire, to the employer in order to obtain the health insurance coverage information.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.

441—75.3(249A) Acceptance of other financial benefits. An applicant or recipient shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or recipient may qualify, unless the applicant or recipient can show an incapacity to do so. Sources of benefits may be, but are not limited to, contributions, annuities, pensions, retirement or disability benefits, veterans' compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

75.3(1) When it is determined that the supplemental security income (SSI)-related applicant or recipient may be entitled to other cash benefits, a Notice Regarding Acceptance of Other Cash Benefit, Form MA-3017-0, shall be sent to the applicant or recipient.

75.3(2) The SSI-related applicant or recipient must express an intent to apply or refuse to apply for other benefits within five working days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or recipient is mentally or physically incapable of filing the claim for other cash benefits.

75.3(3) When the SSI-related applicant or recipient is physically or mentally incapable of filing the claim for other cash benefits, the local office shall request the person acting on behalf of the recipient to pursue the potential benefits.

75.3(4) The SSI-related applicant or recipient shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or recipient shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.4(249A) Medical assistance lien.

75.4(1) The agency within the department of human services responsible for administration of the department's lien is the division of medical services. When payment is made by the department for medical care or expenses through the medical assistance program on behalf of a recipient, the department shall have a lien, to the extent of those payments, to all monetary claims which the recipient may have against third parties. A lien under this section is not effective unless the department files a notice of lien with the clerk of the district court in the county where the recipient resides and with the recipient's attorney when the recipient's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the recipient, the recipient's attorney, or other representative. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final for purposes of this section. A compromise, including, but not limited to, notification, settlement, waiver or release, of a claim under this section does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended. A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a recipient or on behalf of a recipient which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the recipient's claim.